UNITED STATES DISTRICT COURT

WESTERN DISTRICT OF NEW YORK

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GOVERNMENT EMPLOYER'S INS. CO, ET AL. Plaintiffs vs. MIKHAIL STRUTSOVSKIY, M.D. a/k/a Michael Strut, et al. Defendants.
- - - - - - - - - - - - - - - - X

12CV330

Buffalo, New York
February 5, 2015
10:30 a.m.

Motion
Transcribed from an Electronic Recording Device

TRANSCRIPT OF PROCEEDINGS
BEFORE THE HONORABLE JEREMIAH J. MCCARTHY
UNITED STATES MAGISTRATE JUDGE

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GEICO, ET AL. VS. M. STRUTSOVSKIY, ET AL

P R O C E E D I N G S

* * *

THE CLERK: GEICO versus Strutsovskiy, docket No. 12CV330. This is argument on motion for summary judgment. Max Gershenoff appearing on behalf of Plaintiff; Robert Knoer appearing on behalf of defendants.

MAGISTRATE JUDGE SCHROEDER: Good afternoon.

MR. GERSHENOFF: Good afternoon, your Honor.

MR. KNOER: Good afternoon, your Honor.

MAGISTRATE JUDGE SCHROEDER: We're here for argument of Defendants' motion seeking summary judgment.

MR. KNOER: We are.

MAGISTRATE JUDGE SCHROEDER: All right.

MR. KNOER: Would you like me to proceed from here?

MAGISTRATE JUDGE SCHROEDER: Wherever you're most comfortable.

MR. KNOER: I'm comfortable here.

MAGISTRATE JUDGE SCHROEDER: All right.

MR. KNOER: Good afternoon, your Honor. May it please the Court. I represent Dr. Strutsovskiy, identified as Michael Strut, and also his medical practice, which is

identified as RES Physical Medicine and Rehabilitation. I note that the remaining defendants have been dismissed voluntarily, and we're here on the motion for summary judgment on a very narrow issue, Judge. I want to acknowledge to the Court that this issue probably would not have been appropriate on a Rule 12(b)(6) motion, and that is why we didn't make it. This is now summary judgment. We've had significant discovery, depositions, expert exchanges, expert depositions, document exchanges. Mr. Gershenoff and I have been actively at this for a couple of years. And we're down to a point where I think it's a legal issue the Court can rule on as a matter of law; that is why we bring this motion. The issues underlying this case are whether or not certain medical treatments were appropriate, and were appropriately billed for No-Fault reimbursement. Those issues would normally be dealt with in the No-Fault system in the state court, or the state arbitration system set up for No-Fault. The exception, and the reason why GEICO brings this case here, is that there is an exception in the courts and in the case law for fraud. If there is fraud present in these kind of reimbursement cases, then the courts have said you can come out of the no-fault system and deal with it in the state system -- or the federal system. The exception, however, requires fraud. It doesn't require that GEICO doesn't like the no-fault system or hasn't

been successful. They have to show the elements of fraud. Mainly, for the purposes of our argument, and I'll get right to the point, your Honor, it's about reliance and it's about reasonable reliance. We have done a lot of discovery in this case. We've gone through quite a bit of depositions and documents. We brought in the head GEICO guy for the state, and I think for the region, which is multiple states. And we've also discovered through our document demands that in November of 2010, GEICO had made a determination that they did not trust Dr. Strut, period. They did an internal review. They had external referrals to state and federal agencies seeking their review. And they came out with a report dated November of 2010, which basically said, our review is complete, we don't trust him. It's our position that from that point forward, they were not relying on anything that Dr. Strut has admitted or anything that Dr. Strut gave them in making a determination of whether or not to pay. They could have not paid if they believed there was fraud involved here. The no-fault system, and I submitted with our papers a decision from the Department of Insurance, which says very clearly, "a provider can refuse to pay if they believe there is fraud." GEICO had that option. GEICO chose to pay for their own reasons. And I think in their papers, they indicate that the system is a little unfair, in terms of expenses and attorneys fees and interest and things

that might accrue if they're wrong. But in the end, they cannot reasonably say to this Court that after November of 2010, that they themselves internally determined that he was not reliable in their eyes, that they were trusting anything that Dr. Strut says. The second element of our motion is the knowingly false part of fraud. The statement has to be not only incorrect in the sense it's not true, but it has to be knowingly false. To the extent that GEICO feels that the treatments provided, and they're pretty much a wide slot, it's the same type of treatment that is being provided that GEICO doesn't like. To the extent they feel those treatments were not true, they were not correct, they're not materially necessary, and that Dr. Strut, by billing for them, is making a false statement, our response is that Dr. Strut has gone through significant arbitration, not only with GEICO, but with all of the carriers over these exact treatments, these exact tests, these exact billing protocols, the exact manner in which he practices. And I'm not making an estoppel argument, which I think is what GEICO referred to in their papers, that is not the point. The point is consistent, as we indicated, over 90 percent of the time in arbitration, the arbitrators, who in the state system, in the comprehensive No-Fault system, were deferred to as the people to make these determinations, have over 90 percent of the time, said, correct treatment,

appropriately billed, appropriately reimbursed. Now I'm not saying that that makes every single case going forward that Dr. Strut ever bills should automatically be paid. If there is any questions, they should be questioned. But what I am saying is that to the extent he has been told time and time and time and time again by these arbitrators that he is doing it correctly, it cannot possibly be a knowingly false statement to submit the same type of bills for the same type of treatment. One thing is very curious in this case, your Honor. There is not one, not a single affidavit, piece of evidence from a single patient saying that they didn't get the treatment, the treatment wasn't effective, Dr. Strut was doing anything inappropriate. GEICO relies entirely on their expert peer reviews and on their expert reports. Now, we didn't submit an expert report, because, frankly, if it became a battle of the experts, I could not stand here in good conscience and tell the Court that this is something that is appropriate on a motion for summary judgment. That is a fact question. It's an expert battle. That is not where we're at. We're here because, as a matter of law, you have to show -- sorry, Judge -- you have to show reliance. They can't show reliance here. And I don't believe they can show knowing falsehood here on any of these submittals. Now, it's not just us. It's not just Dr. Strut. They make a great bit of noise about Dr. Strut and his past and

his felony conviction and we don't hide from that. It happened and it's there. But it's not us that is saying that GEICO relied, GEICO put in exhibit B or exhibit A, rather, GEICO's own report. Their words, their documents, their report, we don't trust this guy. We took a deposition of GEICO's big guy, didn't trust him, didn't trust him, then, yes, they flagged every single, every single submittal by the tax identification number from where it was coming. They flagged it because they didn't trust it, had to go for further review. So, for GEICO to say at this point they were relying on Dr. Strut and his submittals, is simply, as a matter of law, unsupported. In addition to the fact that there is absolutely no evidence from someone with personal knowledge, that is someone who was present, a patient, that the treatments weren't provided, they weren't provided as billed, et cetera. I think that it's very telling, your Honor, that there is nothing here that supports that.

Now, GEICO, and Mr. Gershenoff, and I respect Mr. Gershenoff, his firm does a lot of these cases. He is going to talk about these kind of cases. He is going to say there are cases in this district and in the Second Circuit and they're all the same, and they're not. They're very distinguished, mainly on two grounds. They are 12(b)(6) motions, which this is not. This is a summary judgment motion after full discovery

or they're default motion in which someone is trying to overturn the default, or they deal with after learned fraud. Situations where it wasn't just unreasonable for the carrier to find the fraud within the short thirty-day window that No-Fault gives you, but situations where they actually didn't find it until sometime later. Medical practice fraud where someone puts together a business that is a fraud in itself. But there is no way for GEICO or the other carriers to know during the No-Fault process, because that is not part of the questions. That is not this case. This case is uniquely one in which, not only did they suspect, they investigated, they reached a determination, they flagged every single submittal. So, those cases are very different. There is a little bit of a tension between the state cases and federal cases. Court of Appeals in New York and the Second Circuit in the districts have a little bit of a twist between this interplay between No-Fault and fraud. The *Fair Price* case, which was a case in which Court of Appeals of New York said, you know, you can't use fraud as a defense after you wait two years in the No-Fault. Fine. We don't disagree with *Fair Price* in any way. We also don't agree that the district court cases or Court of Appeals or the Second Circuit has in some way overruled *Fair Price*. We think they're distinguished. And the big case I think the Court needs to take into account here is there is a recent Court of Appeals

case, a Second Circuit case in *Allstate v. Mun*. And in the *Mun* case, in the *Mun* case there was a question about whether or not the carrier could be compelled to arbitrate claims. And *Mun* said, no, you can't compel to arbitrate these already paid claims and there is a reason for that. But *Mun* also said, if you look at the district court case and the Magistrate report and at the Second Circuit decision, the carrier can be forced to arbitrate not yet paid claims. And I would submit to the Court that there is a reason for that. Number one, the carrier now has information that they believe creates establishes fraud and they should bring that as a defense in the no-fault system, which the no-fault system allows. So, I think in *Allstate v. Lyons*, same thing, the Court said that you can be compelled to arbitrate not yet paid claims. You can be compelled, even though you're alleging fraud, that doesn't get you out of the system of No-Fault, you can be compelled to arbitrate those because you belong in No-Fault.

Now, GEICO doesn't like the No-Fault system and they're not very successful with Dr. Strut's claims in the No-Fault system, and I understand that. But that's a question between them and the New York State legislation. There is a verification process that they can use and other things they can do in that system. They have choices to make. They could choose not to pay a claim. They face consequences, I

acknowledge that, they face potential interest and attorneys' fees. But it's a choice they make, not on the basis of reliance, but on the basis of weighing these economic risks. And that is the point I'm making. GEICO, in any kind of fraud, any kind of fraud, across the board, SEC fraud, fraudulent antiques, whatever you want to do, that critical element of reliance has to be shown, and reasonable reliance has to be shown. And, in their case, based on fraud, common law, RICO, et cetera, if you pull that thread of reliance, the rest of it falls apart. And that is what we have here, Judge. Claims that were paid after 2010, were not paid in reliance on Dr. Strut. Claims that have not yet been paid, belong in the No-Fault system. They don't belong in front of this Court. For this Court to sit in judgment on every single patient, whether every single treatment, and their own experts agree that these types of medical necessity depends on the patient's presentation at the time of the treatment, we would be going through a trial of months if this Court has to go through it. And I think that, for a lot of reasons, your Honor, this case belongs in the state system to the extent that the claims have not yet been paid. To the extent that they paid claims without reasonable reliance, that is not fraud. And to the extent that there were claims paid prior to November of 2010, I would honestly admit that maybe that little piece of this case

remains. But that is our case in a nutshell, your Honor, and I'm prepared to answer any questions, but I think that that really wraps up why we think that this is a proper motion for summary judgment.

MAGISTRATE JUDGE SCHROEDER: All right. Mr. Gershenoff.

MR. GERSHENOFF: Good afternoon, your Honor.

MAGISTRATE JUDGE SCHROEDER: Good afternoon.

MR. GERSHENOFF: Obviously, GEICO opposes the Defendant's motion for summary judgment. As a threshold matter, it's, of course, to know at the outset that it's the movant's burden on a motion for summary judgment to prove beyond a reasonable doubt that the Plaintiff can prove no set of facts in support of its claim in support of the present motion. The defendants have not done that.

MAGISTRATE JUDGE SCHROEDER: Beyond a reasonable doubt? I thought that was a burden only in a criminal case. Preponderance of evidence?

MR. GERSHENOFF: In *Terry vs. Ashcroft*, your Honor, the Court, which was Second Circuit, 2003, the Court said, "that summary judgment may be granted only in circumstances where it appears beyond doubt that the Plaintiff can prove no set of facts in support of its claim."

THE COURT: Beyond doubt, that's different than

beyond a reasonable doubt.

MR. GERSHENOFF: Yes, your Honor, you are correct and I apologize for the misstatement. But as a threshold matter, your Honor, the defendants haven't proven beyond doubt that Plaintiffs can prove no set of facts in support of their claim.

MAGISTRATE JUDGE SCHROEDER: Isn't the phrase, quote, "beyond doubt," synonymous with material fact in dispute?

MR. GERSHENOFF: Well, there are many material facts in dispute in this case regarding the legitimacy of the Defendant's treatment practices, your Honor.

MAGISTRATE JUDGE SCHROEDER: Let me break it down as I understand it from the papers that have been submitted and from Mr. Knoer's argument. Is it factually correct that sometime in 2010, GEICO concluded that it couldn't trust Dr. Strut, and that it was going to really focus on all of his submissions?

MR. GERSHENOFF: Actually, your Honor, I think that is -- that sums up and ends it in somewhat of a misleading way. I would like to tell the Court a little bit about what happened in late 2010.

MAGISTRATE JUDGE SCHROEDER: All right.

MR. GERSHENOFF: All right. In late 2010, GEICO

had received a certain amount of Dr. Strut's claims, he had been submitting the claims at that point for a few months. And it noted several things about the claims and it made them appear suspicious, including the fact that Dr. Strut's treatment notes, to that point, seemed to contain a lot of boiler plate and cut and pasted language, and, also, that Dr. Strut was prescribing a very problematic amount of narcotics to GEICO insureds, which was very incongruous in the context of the relatively minor automobile accidents that the insureds had been involved in. Therefore, GEICO commenced an investigation of Dr. Strut, and concluded that moving forward, Dr. Strut's claims would be flagged for further review as they came in.

MAGISTRATE JUDGE SCHROEDER: Okay. Now, at that point then, there is at least some notice to GEICO?

MR. GERSHENOFF: Yes.

MAGISTRATE JUDGE SCHROEDER: About Dr. Strut?

MR. GERSHENOFF: Yes. And GEICO did, in fact, follow up and review Dr. Strut's claims on an ongoing basis as they came in. However, as we set forth in our papers in opposition to this motion, your Honor, you know, GEICO is constrained in the type of investigation and verification that it can seek by the No-Fault system. The No-Fault regulations require insurers, such as GEICO, to not treat claimants as adversaries, to handle the claims in good faith, these are

written into the No-Fault regulations, and so they have the force of law. What's more, the No-Fault regulations do not, as a practical matter, permit GEICO to conduct any sort of in-depth investigation or to demonstrate on a claim-by-claim basis, whether or not a claimant is engaging in a pattern of fraudulent billing for medically unnecessary or illusory services. As we set forth in our papers, GEICO, when it gets a claim for No-Fault benefits, from Dr. Strut or anyone else, has 15 days to determine whether or not to request additional verification of the claim, and the additional verification of the claim that GEICO is allowed to seek under the No-Fault regulations is rather limited. GEICO can't just ask for anything it wants to. It has to have a reasonable basis for its request for additional verification. And once the -- and if it doesn't, for example, if it makes a request for additional verification or if it delays a claim based on a request for additional verification and it's later determined by a court or an arbitrator that the request was unreasonable, then any subsequent denial of the claim is going to be deemed untimely, and GEICO is going to be liable to pay penalties or, rather, interest and attorneys' fees on the claim. GEICO is, you know, not entitled to ask for whatever it wants in the context of a claim. It can't ask for additional clarification of the universe of a provider's claim when handling a discrete

claim for a discrete insured. And, therefore, there is no way for GEICO, until it received a critical mass of Dr. Strut's claims, as we set forth in the papers, it did not receive a critical mass of Dr. Strut's claims until late 2011, there was no way for GEICO to know the not only individual claims that Dr. Strut had submitted were suspicious, but that Dr. Strut was treating every patient, basically, in the same way, regardless of their individual circumstances that were presented. There was no way to prove that. What's more, Dr. Strut verified each of his claims. Dr. Strut, although he is a convicted felon, and although he was convicted for felony insurance fraud, you know, he is a licensed physician, and his professional corporation is authorized, you know, to provide medical services, and these are the people who were submitting the claims. And they were verifying each and every claim that was submitted pursuant to New York Insurance Law Section 403 that the claim didn't contain any false or misleading information. Insurers such as GEICO are entitled to rely on facially valid claims submitted by licensed health care providers, number one. Number two, even if GEICO wasn't entitled to rely on facially valid claims submitted by licensed health care providers and for that reliance to be reasonable, there was no way, as we set forth in our papers, supported by affidavits by people with first-hand knowledge, there was no way for GEICO, as a

practical matter, to determine that Dr. Strut was providing his medical services or purporting to provide them pursuant to a predetermined fraudulent protocol until after it had received a large number of those claims and could look at the entire universe of claims and see that every patient was receiving substantially the same services and substantially the same pattern, with, you know, substantially the same treatment notes provided, substantially the same massive amounts of narcotics provided to patients who did not need them and so forth. In this context, reliance is typically a fact intensive inquiry. We have put forth ample explanation for why GEICO's reliance was reasonable under these circumstances. It's in our papers, it's in the declaration of Robert Leone, who is the GEICO's claims manager, who was responsible for overseeing the claims handling practices during the pertinent period.

MAGISTRATE JUDGE SCHROEDER: But doesn't it come down to the simple question or issue then, GEICO questioned the necessity of whatever it was that Dr. Strut did for a particular patient when submitting the claim? What you are telling me, as I understand it, is GEICO couldn't do some kind of analysis on one claim or two claims or three claims, it had to wait until it had accumulated a lot of claims to then say, oh, this is a treatment that we now feel it was not necessary or don't believe should have been undertaken only because he

did it for everybody.

MR. GERSHENOFF: I'm not 100 percent clear on the question.

MAGISTRATE JUDGE SCHROEDER: Okay. As I understand your argument, GEICO was not barred from doing what it's presently doing because the Plaintiff claims you relied on the submission of a payment application of Dr. Strut when you had knowledge that you already suspected Dr. Strut of not being properly acting.

MR. GERSHENOFF: We --

MAGISTRATE JUDGE SCHROEDER: That the Plaintiff argues, using the common-law definition of fraud, the person has to rely on what has been presented by the person perpetrating the fraud, and is in a position where that person cannot determine or have knowledge of or a way of reasonably knowing that this is fraudulent, and so relies on what that perpetrator is telling him or presenting to him, and acts in that reliance. As the Plaintiffs' argument is, as I understand it, is when GEICO undertook this investigation in 2010 and concluded that Dr. Strut could not be trusted, now GEICO is in a frame of mind where it isn't going to rely on, as the Plaintiff argues, it isn't going to rely just per se on what is presented by Dr. Strut, it's going to look at whatever Dr. Strut presents with a jaundice eye and make determinations as

to the validity or legitimacy of what is being presented. Your argument, as I understand it, is you can't do that under the insurance regulations on a case-by-case basis, you can't request more detailed information or investigation because you can't penalize the patient or the person who received the treatment by delaying these kinds of payments. But, because of that, GEICO could not really make a fraud claim based on one or two or three or ten. It wasn't until it accumulated a number of claims from Dr. Strut that showed the same pattern and practice of everybody getting the same treatment and, as represented by you, receiving prescriptions, apparently, for drugs or narcotics of an inordinate amount or for injuries that wouldn't seem to require that kind of prescribing, et cetera, and that is when you had enough now to say, there is a fraud here.

MR. GERSHENOFF: That is when GEICO had enough to say that there was a fraud there. But during the preceding period, GEICO was, as a practical matter, forced to rely on Dr. Strut's claims.

THE COURT: Okay. Now, this is where my next question comes. Mr. Knoer says you had a choice, GEICO, pay or refuse to pay.

MR. GERSHENOFF: Mm-hmm.

MAGISTRATE JUDGE SCHROEDER: And if you refuse to

pay, it can go to arbitration.

MR. GERSHENOFF: If GEICO refused to pay, Dr. Strut could take the claim to arbitration, at which point, GEICO would be left without a defense at the arbitration.

MAGISTRATE JUDGE SCHROEDER: But isn't that a problem with the way the No-Fault thing is structured?

MR. GERSHENOFF: Well, as a result, courts have found that insurers, such as GEICO, and insurers are entitled to rely on facially valid claim submissions that are submitted through licensed physicians and licensed medical professional corporations. And, in fact, in that context, your Honor, I would add, that in considering reasonable reliance, courts look at the entire context of the transaction. And that is why reliance is typically not an issue that is decided on summary judgment motions. In this particular case, we would say that looking at the entire context of the transactions at issue, which we've presented to the Court and we explained to the Court, something that was omitted from Dr. Strut's papers on the motion, GEICO was, as a practical matter, forced to rely on the claims or else to find itself in potentially in arbitration with Dr. Strut where it would lack a defense. Now, that is something that the Court can take into account when determining whether or not GEICO's reliance on the facially valid claims submitted through this licensed physician was reasonable or

not. And we would contend that is an issue which should be for the jury, rather than an issue that should be decided on summary judgment.

MAGISTRATE JUDGE SCHROEDER: Am I correct in understanding, GEICO does not say that what is listed by way of what services were rendered did not occur?

MR. GERSHENOFF: No, that is incorrect, your Honor. And several cases, and this is a feature that appeared throughout Dr. Strut's papers, in some cases, GEICO contends -- actually, in every case, GEICO contends that the billed-for services were medically unnecessary.

MAGISTRATE JUDGE SCHROEDER: No, I didn't say unnecessary, but they didn't happen.

MR. GERSHENOFF: I'm getting -- in other cases, GEICO asserts that the billed-for services did not happen at all. They were completely illusory. In particular, your Honor, Dr. Strut, in virtually every case, billed for extremely high-level patient consultations. The kind of examinations that would take place for a cancer patient, HIV/AIDS patient, facing a terminal or seriously life-threatening condition. When, in actuality, to the extent that Dr. Strut provided any patient examinations at all, they were perfunctory examinations, patient examinations, taking a very short amount of time, as evidenced by the fact that his treatment notes were

cut and pasted across, you know, large numbers of patients and didn't materially differ from one patient to another. So, in the first instance, Dr. Strut billed for high-level complex consultations, and I should preface this to the extent the Court is not familiar with it. When a physician or another health care provider bills for a patient examination, he or she has to choose in that bill from a variety of what's called Current Procedural Terminology or CPT codes. And each code that is used corresponds to a certain level and a certain type of service. So, for example, patient examination codes ending in the No. 4 or 5, carry with them the representation that the examination that occurred was extremely high level and complex. Extensive as far as timing, time is concerned, the consultation or examination took a long time to do, it involved an in-depth patient history, it involved an in-depth patient examination. And there are standards that have to be met when you bill under those high-level examination codes. Well, Dr. Strut always or virtually always billed under those high-level examination codes, but, in fact, he never provided high-level examinations. To the extent --

MAGISTRATE JUDGE SCHROEDER: Now, as soon as you see a claim with a code, high-level code --

MR. GERSHENOFF: Mm-hmm.

MAGISTRATE JUDGE SCHROEDER: -- and there is this

15-day window, GEICO could have said, why was it necessary for this high-level examination, what do you have to back it up, couldn't you?

MR. GERSHENOFF: GEICO could have done that and GEICO could have requested Dr. Strut's examination under oath, which it did.

MAGISTRATE JUDGE SCHROEDER: No, no, no, but I'm just talking about in the early stages, when the claim comes in, you have claims examiners.

MR. GERSHENOFF: Mm-hmm.

MAGISTRATE JUDGE SCHROEDER: They see and now they're already on notice anything coming in from Strut, you look at it with jaundice eye. Okay. I have a high-level code, I got 15 days, I question whether all of this was necessary in light of what the factual background is for these injuries. I send out a notice in that 15-day period, I want more detail as to justify as to why you need to do this high-level examination or what documentation do you have to back up the need and the actual performance of this high-level examination.

MR. GERSHENOFF: Sure. And when GEICO would do that, Dr. Strut submitted his examination reports in support of his examinations, which, on their face, touched every base. So, for example, when Dr. Strut would submit a bill under CPT code 99244 or 99245, representing a very high-level

examination, he would, typically, either on his own or at GEICO's request, would submit what purported to be a report of that examination. These reports were multiple-pages long, single spaced. They purported to set forth a highly detailed examination. However, after GEICO had received a critical mass of these claims, which took some time, GEICO discerned at that point that the language in virtually all of these examination reports were cut and pasted. But there was no way for GEICO, getting a bill and examination reports to deny that claim.

MAGISTRATE JUDGE SCHROEDER: Well, let me -- let me -- I will give you my favorite complaint when I'm talking to lawyers in this day and age of technology, which, obviously, is carried over to all of the other fields. Cloning or cutting and pasting is no longer a surprise to anybody. When I see the motions for discovery or bills of particulars or interrogatories or motions to suppress, it's the exact same language from every defendant, and it's the exact same language for every case. I'm assuming the medical field has gotten to the same point that when you got this coding, this is what you got to describe. And some secretary hits the button and it spews it out.

MR. GERSHENOFF: Your Honor, that may be true. I, frankly, am not aware of whether or not doctors routinely cut and paste their treatment records for one patient into the

treatment records of another patient. And, in any case, I don't think -- I don't see how it's really germane to this motion for summary judgment. We allege --

MAGISTRATE JUDGE SCHROEDER: Let me go to another question. This claims examiner now has this detailed report attached and looks at it. It's that detailed report that is going to help someone make a decision whether there is fraud involved or not, aren't they? I mean, claims examiners are trained, you got the code, you know what the code requires as far as treatment, and now you got a detailed report submitted by a physician saying this is what I did.

MR. GERSHENOFF: You have one detailed report.

MAGISTRATE JUDGE SCHROEDER: If you decide it was fraudulent, what was being described in this one report, you're supposed to act upon it within a certain period of time.

MR. GERSHENOFF: Well, you have 30 days to make a decision whether to pay or deny a claim.

MAGISTRATE JUDGE SCHROEDER: Right. But if you read this report and then make a decision to pay, how can you say that you relied on the report as being fraudulent.

MR. GERSHENOFF: You've relied on the facially valid bill and the facially valid treatment report that is submitted by a doctor.

MAGISTRATE JUDGE SCHROEDER: Or you could have

done something within the 15-day period.

MR. GERSHENOFF: You could have requested additional verification, and then to the extent that the provider provides the additional verification, and, by the way, you're limited in the additional verification you can request, you cannot request any kind of esoteric thing you want.

MAGISTRATE JUDGE SCHROEDER: No, I understand. Did GEICO make 15-day requests?

MR. GERSHENOFF: Yes. GEICO did, and Dr. Strut would produce enough to meet the assurances, so to speak, at which point GEICO had to pay the claims as a practical matter. Incidentally, it's worthwhile to note that in the context of the reasonable reliance inquiry, assurances or additional verification in this particular context, is germane to the inquiry. All right? So, a suspicious Plaintiff, okay, who receives assurances from a defendant, that is supposed to be taken into consideration in determining whether or not the Plaintiff's reliance thereafter was reasonable. In this case, Dr. Strut appeared for two examinations under oath to defend his practices, and along the way, also provided additional verification periodically when GEICO would request it. And every single one of his bills was verified pursuant to Insurance Law 403 that it was true and correct, and didn't contain any false or misleading information. In that context,

GEICO's reliance was reasonable. GEICO has put forth, you know, a lengthy explanation of that context in its papers, and we would contend, respectfully, that given the totality of the circumstances here, the reasonableness of GEICO's reliance is appropriate for trial rather than to be determined on summary judgment.

MAGISTRATE JUDGE SCHROEDER: Doesn't it all come down to GEICO saying, we don't agree all of the things that were allegedly done in these submissions and these detailed statements were necessary?

MR. GERSHENOFF: In a manner of speaking. GEICO contends that what Dr. Strut did here -- I should actually start at the beginning, okay? Dr. Strut, shortly after being released from house arrest, after being convicted for felony insurance fraud in this Court, and declaring bankruptcy, he was without credit, he was without malpractice insurance, he is barred for life from billing Medicare because of the Medicare fraud in which he was engaged in. He can't bill major medical ordinary insurance carriers or worker's compensation because he doesn't have any malpractice insurance and can't get malpractice insurance. So, the only thing that he was really eligible to do as a licensed physician was to bill no-fault insurance, which, of course, is more of a state insurance regime. So, he has clearly had a motive to commit fraud or to

at least to engage strictly in a No-Fault practice.

MAGISTRATE JUDGE SCHROEDER: He may have had a motive, but to prove it, motive is on the defense, on the insurance company.

MR. GERSHENOFF: Yeah. And we look forward to proving it at trial, your Honor. We think it's eminently provable given the circumstances of this case. Shortly after he emerged from house arrest, he starts billing GEICO for these types of treatments. And what emerged after he submitted a critical mass of billing to GEICO, and GEICO was able to examine the totality of his billing over a fairly extended period of time, was that every patient would receive a substantially identical diagnosis, regardless of whether they were fat or skinny, old or young, in good health or in bad health, were involved in a serious motor vehicle accident or whether they were involved, as was generally the case, in trivial fender benders. They would all receive substantially identical diagnoses, and they would all receive substantially identical treatment recommendations, and then they would all receive a substantially identical course of treatment, again, regardless of their individual circumstances that were presented. That was a fact pattern that could emerge only after a certain period of time.

MAGISTRATE JUDGE SCHROEDER: With a representative

sample.

MR. GERSHENOFF: A fairly large representative sample, quite frankly. And, what's more, in the context of individualized no-fault insurance arbitrations, GEICO was, as a practical matter, powerless to put evidence of this pattern of fraudulent treatment in front of the arbitrators, because, number one, the arbitrators, No-Fault arbitrations, as set forth in the *Allstate vs. Mun* case, a Second Circuit case, as a practical matter involved typically really no opportunities for discovery, okay. And to the extent that arbitrators, as set forth in our papers, permit any discovery at all in the context of No-Fault arbitrations, it's almost limited to the discrete claim in front of them rather than the universe of claims submitted by a provider. So when GEICO goes, and this is something that I think, frankly, should be taken into account in the context of determining whether or not GEICO was entitled to reasonably rely on the facially -- substantially the claims submitted by Dr. Strut or through his professional corporation, as a practical matter, when GEICO is in a No-Fault arbitration against Dr. Strut or any other provider, that arbitrator is not interested in and will not look at and will not consider and will give GEICO no opportunity to present evidence that the health care provider provided the same treatment to every insured without regard to their individual circumstances

they're presented. All that arbitrator is going to consider is, number one, did the health-care provider make out its prima facie case, which is basically showing that the bill was submitted and wasn't paid, and then the burden goes onto the insurer to show that the treatments were medically unnecessary or were not provided. But, if the evidence of lack of medical necessity or of the treatments not being provided is that the provider was using boiler plate treatment notes across a large universe of patients or that the provider was providing identical treatment to a large number of insureds without regard to their individual circumstances, then the insurer is not going to be able to present that evidence in the context of a PIP arbitration. And that is why GEICO typically loses in PIP arbitrations against Dr. Strut. But, again, in recognition of the fact that this is the state of affairs in the no-fault insurance system, the Department of Financial Services, then it was the Department of Insurance, has explicitly said that an insurer -- the prompt payment provisions of the No-Fault statement present no bar to an insurer later bringing an action in fraud or unjust enrichment to recoup No-Fault benefits that were paid pursuant to a fraudulent scheme, like the one in this case. And I think that's important to note the Department of Insurance, the Department of Financial Services, explicitly has stated, and many courts have deferred to this Insurance

Department, in my opinion, that insurance companies can, in fact, bring these types of actions in deference to the DOI decision, virtually every court to consider the issue -- actually, in fact, every court to consider the issue has deferred to the Insurance Department's position and has rejected contentions like the contentions like Dr. Strut in this case that cases like this somehow have to be folded into the context of a No-Fault arbitration. I mean, that is absurd. As a practical matter, GEICO can't bring civil racketeering claims in a PIP arbitration. The arbitrators would be powerless to award trouble damages. GEICO can't present evidence in the context of a No-Fault arbitration of a pattern of fraudulent billing or a pattern of fraudulent treatment practices. So, it could never prove a RICO claim in the context of PIP arbitration.

Dr. Strut also contends that his success in these discrete and individualized No-Fault PIP arbitrations somehow point to the fact that he didn't have the requisite scienter to commit fraud. I think that with respect to Dr. Strut's state of mind, we've presented considerable evidence to create a fact question with respect to Dr. Strut's fraudulent intent, starting with the fact that he was obviously barred from engaging in a legitimate medical practice and had a motive to commit fraud, and that he was, at the time that he began

billing GEICO, desperate for cash as a result of his bankruptcy and his criminal conviction and his inability to obtain, you know, highly remunerative medical employment. You know, and I think that's important to note. I don't think it's fair to say at all that it's appropriate to resolve the question of Dr. Strut's scienter on a motion for summary judgment based solely on the fact that he was successful in No-Fault arbitrations over time, and, therefore, believed that the treatment and the things he was doing and billing for were somehow legitimate. In this context, we've also presented, and it's worthwhile to note, we've presented in opposition to this motion, the opinions of and affidavits from two very distinguished physicians. One a pain management professor at Johns Hopkins University; and another the Chief of Physical Medicine and Rehabilitation at North Shore University Hospital. Both of them have concluded, not only that Dr. Strut routinely billed for medically unnecessary or illusory services, but also that Dr. Strut had to know that he was billing for medical unnecessary or illusory services based on the way he was submitting his billing. And, also, incidentally, that the manner in which Dr. Strut was purporting to treat his patients, to the extent the treatments were provided at all, demonstrated a disregard for the patient's welfare. And if the Court were to read our papers, and I'm sure the Court has, I'm sure the

Court would note that some of the aspects of what Dr. Strut was doing were extremely troubling. He was billing for -- or rather he was providing GEICO insureds, who were involved in minor automobile accidents, truly trivial fender benders, low speed, low-impact, rear-end collisions in parking lots, things of that nature, with massive amounts of narcotics and other habit-forming drugs. Oftentimes, in many cases, and we cite them in our papers, and they are certainly cited by our experts in their affidavits, oftentimes, despite clear indications that the drugs were being abused or diverted, and often despite clear indications that the patients had preexisting substance abuse problems and shouldn't have been getting narcotics from Strut in the first place. We've alleged in our complaint, that Dr. Strut used these narcotic prescriptions to incentivize the insured to report on a continuing basis for medically useless or illusory treatments. Quite frankly, Dr. Strut contends that we haven't presented any patient testimony in opposition to the summary judgment motion. That is fairly rich, your Honor, considering that Dr. Strut, whose burden -- who has got the burden on this motion himself, apparently was not able to come up with a single patient of his who was a GEICO insured to come in and testify that they got his treatments or that they obtained any medical benefit from his treatments or that the treatments were medically necessary. Although Dr. Strut hired

an expert in this case, and produced the expert for a deposition, not only has it emerged, as we set forth in our papers, that the expert has actually had a long and intimate personal relationship with Dr. Strut and actually pleaded for clemency for Dr. Strut in his criminal case, but the expert also, during his deposition, repeatedly confirmed that the way that Dr. Strut was purporting to treat the GEICO insureds fell below the standard of care and was not what he would have done under analogous circumstances.

So, you know, the bottom line for us, your Honor, is it's Dr. Strut's burden on this motion to show that he was entitled to summary judgment. As Mr. Knoer points out, his arguments boil down to a contention that GEICO can't show reasonable reliance and a contention that GEICO can't establish the scienter necessary to ultimately prove its fraud or racketeering claim. Well, we would submit to the Court, your Honor, that the reasonableness of GEICO's reliance is something that must be considered in the context of the totality of the circumstances. We've come forward with a large -- a lengthy explanation of what those circumstances were surrounding the submission and handling of Dr. Strut's claims. We contend that in the totality of those circumstances, GEICO's reliance was, in fact, reasonable, or, at a minimum, the reasonableness of GEICO's reliance really should be a question for the fact

finder. I point to the cases in our papers which state that an insurance company is entitled to rely on facially valid claim submissions. Courts have come to that conclusion over and over again. They've come to that conclusion on 12(b)(6) motions, but they've also held, as a matter of law, that in New York, an insurance company is entitled to rely on claim submissions. Again, Dr. Strut provided reassurances with respect to his treatments over the course of time. That also bears on the reliance inquiry. And, finally, what's more, every single one of Dr. Strut's bills was verified. And I think that what it comes down to is what kind of world do we want to live in? Do we want to live in a world where a license to practice medicine doesn't carry with it any responsibilities and obligations? In this particular case, Dr. Strut, a licensed physician, submitted claims to GEICO. The question is: Can insurance companies rely on claims that are submitted by licensed doctors? And they should be able to, your Honor. And, I think, that is one of the considerations that has led court after court after court to reject motions to dismiss these types of claims despite contentions by the movants that the insurer Plaintiffs were sophisticated, had claims verification tools at their disposal, that could or should have entitled or enabled them to uncover the fraudulent scheme earlier, and, thereby, obviate any reasonable reliance. Well, it's true that

insurance companies, like GEICO, do have claim verification tools at their disposal. But it's equally true that those tools are limited and that the No-Fault insurance regulations obligate insurers, as a practical matter, to handle claims in an expedited fashion, in good faith, and to not treat claimants as an adversary. And as a consequence of that, the Department of Financial Services has explicitly held that the expedited claims handling requirements of the No-Fault laws present no bar to a subsequent insurer action to recoup benefits.

And just, finally, with respect to Dr. Strut's scienter arguments, again, you know, we have, at a minimum, presented considerable evidence that Strut had a motive and opportunity to commit fraud and that he had fraudulent intent when he submitted these bills. Although he may contend through his own conclusory statements, that because the No-Fault arbitrators were issuing awards in his favor, he reasonably believed that his treatment and billing practices were legitimate, we would respectfully submit that is a question for the fact finder as well, your Honor, in light of the considerable evidence of motive and fraudulent intent that we've submitted here.

Other than that, we would simply, just to handle a few of the remaining arguments that were raised in Dr. Strut's papers, but not by Mr. Knoer here today, we would point out to

the Court that GEICO's fraud-based claims have been pleaded with the requisite particularity. Although, Rule 9(b) issues can be raised on a motion for summary judgment, we would point out to the Court that literally in dozens of the cases, admittedly mostly from the Eastern District and Southern District of New York, dozens of cases have concluded that virtually identical pleadings with a virtual level, identical level of detail were sufficient under Rule 9(b). We've cited those cases in our papers. I don't think there is a colorable argument to be made here that our pleading is somehow insufficient as a matter of law. And, Dr. Strut also raised an argument to the effect that to the extent that our RICO claims are denied, the Court should decline to exercise supplemental jurisdiction of the remaining claims. We, respectfully, would point out that that ignores the fact that we've alleged completely diverse parties in the requisite jurisdictional amount. I think that's it for the Plaintiffs, your Honor. Thank you very much.

MAGISTRATE JUDGE SCHROEDER: All right. Mr. Knoer, anything you want to add?

MR. KNOER: Very briefly, Judge. First point I just want to get back to, Mr. Gershenoff kept saying that GEICO's hands were constrained, there is little verification. The reality is, as soon as GEICO received a reimbursement form,

they had the ability to issue a notice to the patient, to the doctor to appear in front of a person and in front of an attorney and give testimony. There is no better verification. They could have brought in a patient and they could have asked them the question, and they could have found out what happened. The fact they didn't, doesn't relieve them of their duty to do that under No-Fault.

MAGISTRATE JUDGE SCHROEDER: No. But as I understand GEICO's argument is, claim A comes in, they look at it and say, okay, we'd like this additional information and we want to bring the patient in and so on and so forth. By just having one, that isn't sufficient to establish a pattern and practice.

MR. KNOER: True.

MAGISTRATE JUDGE SCHROEDER: And that they can't do that with each and every individual claim because they are supposed to process those claims in good faith and get them paid within a reasonable period of time. Then that it wasn't until, now they got thirty, forty or more of these claims, when they put them in front, they say, okay, when we look at the language of what was done and the codes that were used, everything is exactly the same, regardless of whether the person was in the front seat or the back seat, whether it was a rear ender, a t-bone accident or whatever, everything is

duplicated, there is no change, et cetera, et cetera, now I've got a fuller picture or better picture, and this isn't making any sense, and now I can start really doing something of substance as far as claiming fraud. That is what I understand the Defendants' argument to be and why this taking one individual claim in a snapshot type of situation wasn't going to do it for them and it couldn't do it for them.

MR. KNOER: And I agree with that.

MAGISTRATE JUDGE SCHROEDER: Okay.

MR. KNOER: And, in November of 2010, they had made a determination, written a report that --

MAGISTRATE JUDGE SCHROEDER: Right, you just told me that.

MR. KNOER: That they were cookie cutter. It's part of the report, they looked at a bunch of claims Dr. Strut had been submitting, they were cookie cutter, he was using a template, he was prescribing excessive amount of prescriptions, the automobile accidents were of minimal impact, et cetera, et cetera, et cetera, all the things that they are now claiming. And I don't disagree with the 2000 insurance letter that they keep referencing here and all of the cases that they bring. But if you read the language of that letter, it says, "there is no reason to deny the No-Fault claim at the time payment is due." So the Department of Insurance said, look, we're not

going to penalize you when you comply with the rules when there is no reason to deny the No-Fault claim at the time payment is due. And then a few months later in 2001, they issued the opinion that we put in our papers, which made it very clear to the carrier, "insurer may delay payments under No-Fault portion of its insured policy due to the suspicion of fraud in a claim submission." The conclusion is, yes. So the Insurance Department told the carriers in 2001, yeah, if you pay a claim and then later find out that it was fraudulent, we're not going to penalize you, you can bring it for that. But they also told them, if you suspect fraud and believe there is fraud, you have a right not to pay. And during that period, they could have asked the patient to come in, Dr. Strut to come in, and everyone to come in. I think their argument might be a little more compelling if they were able to prove any one time that what they're claiming happened happened. They haven't. They haven't brought in a patient, they haven't brought in anybody. So, they say there is this massive across-the-board fraud happening with all these patients, but they haven't proven a one. Ninety percent of the times, they're not successful in arbitration. They can ask for patient depositions and bring those depositions to arbitration. They can bring the patient records. They can subpoena other doctors, because many times these patients are being treated by more than one physician for

different reasons. They can bring in other doctors. They can do anything in arbitration. The idea that Mr. Gershenoff is expressing that some of their hands are tied, well, they may be tied economically because they don't want to spend their money there. That doesn't mean they come to Federal Court and bring a fraud claim here. I don't disagree, your Honor, with the idea that the first claims, second claims, tenth claims, twentieth claims, fiftieth claim might not have been enough. But once they put in writing in 2010 and acknowledge that they didn't trust Dr. Strut, there is no longer reliance that can be reasonable. And even their own insurance opinion indicates that if you have reason to deny it, you should do it.

MR. GERSHENOFF: May I just briefly respond, your Honor?

MAGISTRATE JUDGE SCHROEDER: Sure.

MR. GERSHENOFF: As I previously noted and just in response to Mr. Knoer, GEICO did bring Dr. Strut in for examinations on direct, twice, along the way. Now, when Dr. Strut first began to submit his bills, and this is set forth in our papers, when Dr. Strut first began to submit his bills and GEICO completed its initial investigation into Dr. Strut in late 2010, it requested Dr. Strut come in and appear for an examination under oath, which he did in December of 2010. And he attempted to justify his claims practices and his treatment

practices. And once that examination under oath was finished and Dr. Strut had given his reassurances, GEICO, as a practical matter, had no choice but to rely on his claims. However, in order to make sure -- well, let me retract that. Then what happened was in early 2011, Dr. Strut stopped submitting his claims under his own name and he began to submit his claims through a medical professional corporation, RES Physical Medicine, which is also a defendant in this case. It took GEICO a few months, as described in our papers, a few months to realize that RES Physical Medicine and Dr. Strut were one in the same. Once GEICO realized that that was the case, I requested Dr. Strut's examination under oath again. The examination under oath was completed between May and July of 2011. And during that period, Dr. Strut, once again, gave assurances as to the legitimacy of his treatments and billing practices. And, again, you know, GEICO could not, after getting claims by Dr. Strut, ask for a separate examination under oath or separate additional verification for every single one of those claims. It couldn't do it. It wouldn't meet the good-faith requirements and the don't treat the claimant as an adversary requirements as are set forth in the No-Fault regulations. But GEICO did act to try and verify Dr. Strut's claims, and Dr. Strut came in and provided that additional verification and provided assurances. And, in the context of

that, you know, that is something that should be considered in determining whether GEICO's reliance was reasonable. After Strut came in and gave those examinations under oath, GEICO couldn't just deny the claims and say, well, you came in and gave us additional verification, you provided assurances with respect to your claims submission practices, but we're going to deny the claim anyway. Okay? GEICO can't do that. You know, listen, once the additional verification is provided, GEICO has 30 days to make a decision whether to pay or deny the claim. And if it denies the claim, it better have a good reason, because if it denies the claim without a sufficient reason, it's going to lose at arbitration and it's going to be obligated to pay all of the penalties and things like that. So, the system does create some perverse incentives for insurance companies, but those are incentives that should be considered in the context of determining whether or not GEICO's reliance was reasonable. And, again, it's important to emphasize that when confronted with similar arguments in the context of 12(b)(6) motions, multiple courts, in Federal Courts in the Second Circuit, have determined that insurance companies should be entitled to rely on facially valid claim submissions that are verified by licensed physicians. And if they can't be, then we've got a problem in our society. Because it means that a doctor's medical license means absolutely nothing and

you can't trust a doctor to act with integrity and with professional integrity. And I don't think that is the kind of world we want to live in. And I don't think that is -- that the law of the (inaudible) would fail to take that into account. Thank you.

MAGISTRATE JUDGE SCHROEDER: Okay, I understand the position of the parties. I'll reserve. As both of you know, all I can do is a Report and Recommendation to the district judge who has this case.

MR. KNOER: Thank you, your Honor.

MR. GERSHENOFF: Thank you, Judge.

MAGISTRATE JUDGE SCHROEDER: Thank you.

CERTIFICATE OF TRANSCRIBER

I certify that the foregoing is a correct transcript from the official electronic sound recording of the proceedings in the above-entitled matter.

/s Karen J. Bush, RPR

Official Court Reporter